
Notice of Independent Medical Review Determination

Dated: 10/14/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/11/2013
Date of Injury:	1/25/1992
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002512

- 1) MAXIMUS Federal Services, Inc. has determined the request for a medical bed **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Restoril 30mg #30 with 2 refills **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20mg #30 with 2 refills **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a urine drug screen **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a motorized wheelchair **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for a zero gravity chair **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for a medical bed **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Restoril 30mg #30 with 2 refills **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Prilosec 20mg #30 with 2 refills **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a urine drug screen **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a motorized wheelchair **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for a zero gravity chair **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 11, 2013:

“The patient is a 55 year old male with a date of injury of 01/25/1992. The provider is requesting prospective authorization for 1 medical bed, 1 prescription of Restoril 30mg #30 with 2 refills, 1 prescription of Prilosec 20mg #30 with 2 refills, 1 urine drug test, 1 wheelchair motorized, 1 spine surgery consultation and 1 zero gravity chair.

“A review of the patient’s most recent examination completed on 6/26/13 by Dr. [REDACTED] indicated the patient was under care due to pain in his lumbar spine. The patient rates the pain at 7/10 and the pain radiates down the leg. The patient was diagnosed with 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine and musculoligamentous sprain of the lumbar spine. The patient

was currently taking Prilosec and Restoril. The patient was instructed to remain off of work until 08/05/2013.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (received 7/22/13)
- Utilization Review Determination from [REDACTED] (dated 7/11/13)
- Medical records from [REDACTED] Attorneys at Law
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for a medical bed:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Low Back Chapter, Mattress section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not address the issue in dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 1/25/1992 and has experienced partial disability due to pain in the neck, shoulders, arms, and lumbar spine with radiation to the legs. Diagnoses include 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine, and musculoligamentous sprain of the lumbar spine. Treatment has included medications, lumbar epidural steroidal injections, lumbar facet blocks, use of both a cane and a walker, use of a back brace, and other modalities. The request is for a medical bed.

The ODG does not recommend the use of a medical bed. The ODG indicates that there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. The guideline does not support the request. The request for a medical bed **is not medically necessary and appropriate.**

2) Regarding the request for Restoril 30mg #30 with 2 refills:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (current version), Pain Chapter, Benzodiazepines section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the

Chronic Pain Medical Treatment Guidelines (2009), page 24, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/25/1992 and has experienced partial disability due to pain in the neck, shoulders, arms, and lumbar spine with radiation to the legs. Diagnoses include 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine, and musculoligamentous sprain of the lumbar spine. Treatment has included medications, lumbar epidural steroidal injections, lumbar facet blocks, use of both a cane and a walker, use of a back brace, and other modalities. The request is for Restoril 30mg #30 with 2 refills.

Restoril is a benzodiazepine. The MTUS Chronic Pain Medical Treatment Guidelines indicate benzodiazepine use should be limited to four weeks and that this medication is not recommended for long term use. According to the medical records provided for review, the employee was using Restoril since 10/16/2012, demonstrating long term usage over the four weeks limitation. The request for Restoril 30mg #30 with 2 refills **is not medically necessary and appropriate.**

3) Regarding the request for Prilosec 20mg #30 with 2 refills:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), NSAIDs section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 1/25/1992 and has experienced partial disability due to pain in the neck, shoulders, arms, and lumbar spine with radiation to the legs. Diagnoses include 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine, and musculoligamentous sprain of the lumbar spine. Treatment has included medications, lumbar epidural steroidal injections, lumbar facet blocks, use of both a cane and a walker, use of a back brace, and other modalities. The request is for Prilosec 20mg #30 with 2 refills.

The MTUS Chronic Pain Medical Treatment Guidelines do not recommend the use of Prilosec, which is a proton pump inhibitor (PPI) medication under the non-steroidal anti-inflammatory drug (NSAID) section. According to the medical records provided for review, the employee has been using Prilosec since at least 10/16/2012. The available records did not show any gastrointestinal (GI) risk factors, or GI issues that would require a PPI such as Prilosec. The request for Prilosec 20mg #30 with 2 refills **is not medically necessary and appropriate.**

4) Regarding the request for a urine drug screen:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator referenced guideline(s) but did not include any citations. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 43, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related injury on 1/25/1992 and has experienced partial disability due to pain in the neck, shoulders, arms, and lumbar spine with radiation to the legs. Diagnoses include 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine, and musculoligamentous sprain of the lumbar spine. Treatment has included medications, lumbar epidural steroidal injections, lumbar facet blocks, use of both a cane and a walker, use of a back brace, and other modalities. The request is for a urine drug screen (UDS).

The MTUS Chronic Pain Medical Treatment Guidelines recommend UDS to assess compliance or presence of illegal drugs. According to the medical records provided for review, there have only been 2 UDS in 2012 and 2 in 2013, which produced inconsistent results. Two drug tests per year are not unreasonable and are in accordance with MTUS Chronic Pain guidelines. The request for a urine drug screen **is medically necessary and appropriate.**

5) Regarding the request for a motorized wheelchair:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific section. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not address the requested treatment. The Expert Reviewer based his/her decision on the ODG, Knee and Leg Chapter, Wheelchair section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 1/25/1992 and has experienced partial disability due to pain in the neck, shoulders, arms, and lumbar spine with radiation to the legs. Diagnoses include 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine, and musculoligamentous sprain of the lumbar spine. Treatment has included medications, lumbar epidural steroidal injections, lumbar facet blocks, use of both a cane and a walker, use of a back brace, and other modalities. The request is for a wheelchair motorized.

The ODG does not recommend power mobility devices if there is any mobility with canes. According to the medical records provided for review, the employee is able to ambulate with a cane and can walk on a treadmill. The employee is legally blind. The motorized wheelchair was prescribed so the employee can “get out” more often. MTUS Guidelines do not recommend the use of a motorized wheelchair. The request for a motorized wheelchair **is not medically necessary and appropriate.**

6) Regarding the request for a zero gravity chair:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to MakeHis/Her Decision:

The Claims Administrator based its decision on the following article: Toward Optimized Practice. Guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2011, page 37, which is peer-reviewed scientific medical evidence that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined that the MTUS does not address the requested treatment. The Expert Reviewer was unable to find peer-reviewed scientific medical evidence that addresses the requested treatment. The Expert Reviewer based his/her decision on The Medicare Claims Processing Manual, Chapter 20, Durable Medical Equipment (DME), which is a nationally-recognized professional standard.

Rationale for the Decision:

The employee sustained a work-related injury on 1/25/1992 and has experienced partial disability due to pain in the neck, shoulders, arms, and lumbar spine with radiation to the legs. Diagnoses include 3-4mm disc bulge/protrusion at L3-4/L5-S1, degenerative disc disease of the lumbar spine, and musculoligamentous sprain of the lumbar spine. Treatment has included medications, lumbar epidural steroidal injections, lumbar facet blocks, use of both a cane and a walker, use of a back brace, and other modalities. The request is for a zero gravity chair.

According to the Medicare Processing Manual, a zero gravity chair does not meet the definition of durable medical equipment. It is a recliner, and not primarily or customarily used to serve a medical purpose. Anyone can sit in it in the absence of an illness or injury. The request for a zero gravity chair **is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/mbg

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.